

**Health Priority: Tobacco Use and Exposure**  
**Objective 2: Tobacco Cessation**

**Long-term (2010) Subcommittee Outcome Objective:** By 2010, reduce tobacco use by Wisconsin adults and young adults (18-24) by 20%.

Inputs	Outputs		Outcomes		
	Activities	Participation/ Reach	Short-term 2002-2004	Medium-term 2005-2007	Long-term 2008-2010
<ul style="list-style-type: none"> <li>• Funding (both public and private) and in-kind services</li> <li>• Coalitions</li> <li>• Public Policy</li> <li>• Training and Technical Assistance</li> <li>• Materials and Resources</li> <li>• Media</li> </ul>	<ul style="list-style-type: none"> <li>• Training and Technical Assistance</li> <li>• State and Local Policy and Legislative Support</li> <li>• Comprehensive Programs</li> <li>• Materials and Resources</li> <li>• Media and Counter-marketing</li> <li>• Local Coalitions</li> <li>• Monitoring and Evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Local Coalition Members</li> <li>• Youth Leaders</li> <li>• General Public</li> <li>• Health Care Providers</li> <li>• Business Leaders</li> <li>• Policymakers</li> <li>• Local health departments</li> <li>• Tribal agencies</li> </ul>	By 2004, reduce tobacco use by adults and young adults (18-24) by 5%.	By 2008 reduce tobacco use by adults and young adults (18-24) by 10%.	By 2010, reduce tobacco use by adults and young adults (18-24) by 20%.

## Health Priority: Tobacco Use and Exposure

### Objective 2: Tobacco Cessation

#### Long-term (2010) Subcommittee Outcome Objective:

By 2010, reduce tobacco use by Wisconsin adults and young adults (18-24) by 20%.

Wisconsin Baseline	Wisconsin Sources and Year
Wisconsin Adults 24%	Wisconsin Behavioral Risk Factor Survey, 2000.
Wisconsin Adults (18-24 years) 40%	Wisconsin Behavioral Risk Factor Survey, 2000.
Cigarette Sales: 426.5 million Annual per capita: 80.1 packs	Wisconsin Department of Revenue, 2000.

Federal/National Baseline	Federal/National Sources and Year
U.S. Adults 23% (median)	National Health Interview Survey
U.S. Adults (18-24 years) 31% (median)	National Health Interview Survey
41 % of adult smokers ages 18 years and older stopped smoking for 1 day or longer because they were trying to quit in 1998 (age adjusted to the year 2000 standard population). Target: 75 %.	<i>Healthy People 2010</i> . USDHHS, November 2000. 2 <sup>nd</sup> ed.
14 percent of females aged 18 to 49 years stopped smoking during the first trimester of their pregnancy in 1998. Target: 30 %.	<i>Healthy People 2010</i> . USDHHS, November 2000.

Related USDHHS Healthy People 2010 Objectives			
Chapter	Goal	Objective Number	Objective Statement
1 – Access to Quality Health Services	Improve access to comprehensive, high-quality health care services	1-2	(Developmental) Increase the proportion of insured persons with coverage for clinical preventive services.
		1-3	Increase the proportion of persons appropriately counseled about health behaviors.
3- Cancer	Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.	3-1	Reduce the overall cancer death rate.
		3-2	Reduce the lung cancer death rate.
		3-6	Reduce the oropharyngeal cancer death rate.

Related USDHHS Healthy People 2010 Objectives			
Chapter	Goal	Objective Number	Objective Statement
12- Heart Disease and Stroke	Improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and prevention of recurrent cardiovascular events.	12-1	Reduce coronary heart disease deaths.
		12-7	Reduce stroke deaths.
16 – Maternal, Infant, and Child Health	Improve the health and well-being of women, infants, children and families.	16-1	Reduce fetal and infant deaths.
		16-6	Increase the proportion of pregnant women who receive early and adequate prenatal care.
		16-10	Reduce low birth weight and very low birth weight.
		16-11	Reduce preterm births.
		16-17	Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
21 – Oral Health	Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.	21-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage.
24 – Respiratory Diseases	Promote respiratory health through better prevention, detection, treatment, and education efforts.	24-1	Reduce asthma deaths.
		24-2	Reduce hospitalizations for asthma.
		24-3	Reduce hospital emergency department visits for asthma.
27 – Tobacco Use	Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.	27-5	Increase smoking cessation attempts by adult smokers.

Related USDHHS Healthy People 2010 Objectives			
Chapter	Goal	Objective Number	Objective Statement
27 – Tobacco Use	Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.	27-6	Increase smoking cessation during pregnancy.
		27-8	Increase insurance coverage of evidence-based treatment for nicotine dependency.

Definitions	
Term	Definition
Current smoker	Smoked 100 cigarettes in lifetime and smoke currently.
Current use of tobacco	Use of cigar, or smokeless tobacco or those who have ever used previously.

### Rationale:

- Programs that successfully assist adult and young adult smokers in quitting can produce a quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program.
- Because tobacco use is linked with numerous adverse health outcomes, reducing tobacco use will reduce illness, disability, and death across a spectrum of conditions, including heart disease, cancer, and lung disease.
- Smokers who quit smoking before age 50 cut in half their risk of dying in the next 15 years. (1)
- Cost savings from reduced tobacco use resulting from the implementation of moderately priced, effective smoking cessation interventions would more than pay for these interventions within 3-4 years. (2)
- One smoker successfully quitting reduces the anticipated medical costs associated with acute myocardial infarction and stroke by an estimated \$47 in the first year and \$853 during the next 7 years. (3)
- Smoking cessation is more cost-effective than other commonly provided clinical preventive services, including mammography, colon cancer screening, PAP tests, treatment of mild to moderate hypertension, and treatment of high cholesterol. (4-6)
- Evidence-based clinical practice guidelines on cessation have found that brief advice by medical providers to quit smoking is effective. (7)
- Wisconsin women smoke at the rate 39% higher than the national average. (9)
- Smoking accounts for 20 to 30 percent of all low birth weight births in the United States. The effects of smoking on low birth weight appears to be attributable to intrauterine growth retardation rather than to preterm delivery (8)
- The health effects of cigarette smoking have been well documented since the first Surgeon General's report was published in 1964.
- A variety of smoking cessation interventions are effective: (1) simple advice to quit by a clinician; (2) individual and group counseling; and (3) telephone hotlines and help-lines; and (4) nicotine replacement therapy.
- To achieve the individual behavioral change that supports the non-use of tobacco, communities must change the way tobacco is promoted, sold, and used while changing the knowledge, attitude

and practices of tobacco users. An essential element in programs for reducing tobacco's appeal is to change the current social environment that reinforces the acceptability of tobacco use. This change requires strategies to counter the vast amount of money spent on tobacco advertising and promotion that bombards us with false and misleading messages and images about tobacco.

- Effective reduction of tobacco use will require payors and health care systems to make institutional changes resulting in systematic identification of and intervention with, all tobacco users at every visit.
- In 1996, the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) sponsored an expert panel that produced an evidence-based guideline that evaluated smoking cessation interventions available at the time and concluded that the efficacy of intervention increases with intensity.
- To achieve the individual behavior change that supports the nonuse of tobacco, communities must change the way tobacco is promoted, sold, and used while changing the knowledge, attitudes, and practices of tobacco users and nonusers.
- Community efforts to reduce tobacco use requires population-based interventions which emphasize prevention of initiation, reduction of exposure to environmental tobacco smoke, and systems changes to promote smoking cessation.
- A variety of smoking cessation interventions are effective: simple advise to quit by a clinician (30 percent increase in cessation), individual and group counseling (doubles cessation rates), telephone hotlines, help-lines (40 % increase in cessation), and nicotine replacement therapy. The Agency for Healthcare Research and Quality guidelines recommend both pharmacotherapy and counseling be provided as paid services and that providers be reimbursed for delivering effective smoking cessation interventions.

## **Outcomes:**

### **Short-term Outcome Objectives (2002-2004)**

By 2004, reduce tobacco use by adults and young adults (18-24) by 5%.

- Increase awareness and knowledge about negative health consequences of tobacco use to promote attitudinal change.
- Increase availability of comprehensive tobacco cessation programs.
- Residents and legislators will support and promote a comprehensive community tobacco control program.

### **Medium-term Outcome Objectives (2005-2007)**

By 2008 reduce tobacco use by adults and young adults (18-24) by 10%.

- Communities will work to de-normalize the use of tobacco.
- Increase coverage for cessation programs and other pharmacotherapies.
- Health care providers will support and implement clinical practice guidelines for cessation as identified by Agency for Healthcare Research and Quality.
- Community will support and engage in active tobacco control advocacy.

### **Long-term Outcome Objectives (2008-2010)**

By 2010, reduce tobacco use by adults and young adults (18-24) by 20%.

- Community will support and maintain strong tobacco control policies at the state and local level to reduce tobacco use.
- Identify new innovative cessation strategies that meet best practice guidelines for cessation.

**Inputs:** *(What we invest – staff, volunteers, time money, technology, equipment, etc.)*

Note: All inputs apply to all activities and groups we are trying to reach, thus applying to short, medium and long-term outcomes.

Funding: Funding (both public and private) and in-kind services (such as buildings, staff, training, materials) in support of effective tobacco prevention and control.

Coalitions: Engaging the developing existing and emerging tobacco prevention and control coalitions in every county of the state. Coalitions should have participation for key community systems and organizations including but not limited to health care providers/systems, families, youth, public health organizations, local health departments, tribal agencies, faith community, schools, law enforcement, youth-serving organizations, community-based organizations, work sites, businesses, local policy leaders, and others. The coalitions will plan, implement, and evaluate local policy and program initiatives.

Public Policy: Laws, regulations, and policies that support youth prevention, cessation, and the elimination of exposure to secondhand smoke

Training and Technical Assistance: Training and technical assistance infrastructure to provide support for state, regional, and local partners and assure the use of best practices and effective processes in planning, implementing, and evaluating tobacco prevention and control initiatives.

Materials and Resources: Research-based and proven materials for use by state, regional and local partners in the planning, implementation, and evaluation of effective tobacco prevention and control initiatives.

Media: An aggressive media and counter-marketing campaign to raise awareness and prompt action in support of state and local tobacco prevention and control initiatives.

**Outputs:** *(What we do – workshops, meetings, product development, training. Who we reach- community residents, agencies, organizations, elected officials, policy leaders, etc.)*

Note: All activities apply to all inputs and groups we are trying to reach, thus applying to short, medium, and long-term outcomes.

*Activities:*

Training and Technical Assistance: Statewide and regional partners will provide an array of support for the implementation of best practices, including expertise in community development, coalition development, program planning and evaluation, and effective policy change and cessation support.

State and Local Policy and Legislative Support: State, regional, and local partners will support policy and legislation that foster tobacco prevention and control programs and activities.

Comprehensive Programs: State, regional, and local partners will implement comprehensive program consistent with the Centers for Disease Prevention and Control guidelines.

Materials and Resources: All partners should have access to materials and resources that reflect the most effective programs and policies.

Media and Countermarketing: An aggressive media and counter-marketing efforts should support local action to prevent and reduce tobacco use.

Local Coalitions: Local coalitions should be adequately funded and supported in order to lead local efforts to prevent and reduce tobacco use.

Monitoring and Evaluation: All programs and activities should be held to the highest standards of program outcome. In addition, tobacco use trends should be monitored regularly to demonstrate progress toward overall objectives.

### *Participants/Reach:*

Local Coalition Members: Members of local coalitions should lead the statewide effort and should be supported by and engaged in inputs and outputs.

Youth Leaders: Youth are valuable leaders for both youth and adult-targeted activities. Youth should be engaged in program planning and implementation of tobacco prevention and control activities.

General Public: The majority of people do not smoke and should be engaged in comprehensive efforts to prevent and reduce tobacco use.

Health Care Providers: Doctors, nurses, physician assistants, and all health care providers should be engaged in implementing the Clinical Guidelines for cessation programs, in addition to taking part in larger comprehensive efforts.

Business Leaders: Business leaders bear health care, lost productivity, and cleaning costs associated with tobacco and can be valuable leaders in state and local tobacco prevention and control efforts.

Policymakers: Appointed and elected officials both at the state and local levels should be engaged in facilitating state and local policy change and the implementation of comprehensive efforts.

### **Evaluation and Measurement:**

Progress in the tobacco outcome objectives can be measured with Wisconsin Behavioral Risk Factor Surveillance System (BRFSS), the Smoking Attributable Morbidity and Mortality and Economic Cost (SAMMEC) Report, hospitalization records, workplace smoking restrictions, and consumption information, and excise tax reports. Contained in Appendix A are the critical indicators found in these surveys and databases. It is anticipated that these same indicators will continue to exist in the future in order to plan and evaluate progress on a continuous basis.

Limitations with current data include:

- Many current databases do not provide adequate and statistically significant data on specific population groups, including populations disparately impacted by tobacco and information on racial and ethnic populations.
- Many current data sets are statewide samples and do not provide municipal level data for all communities.

(For summary of data elements, refer to the *Wisconsin Tobacco Facts*, produced by the Wisconsin Tobacco Control Program, Division of Public Health.)

### **Indicators:**

- Percentage of 18-24 year olds who use tobacco products.
- Percentage of adults who use tobacco products.
- Percentage of health care providers who implement clinical practice guidelines (i.e., Agency for Health Research and Quality).
- Policy maker support (voting record) for comprehensive tobacco control programs.

### **Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010**

*Access to Primary and Preventive Health Services:* The Agency for Health Care Policy and Research evidence-based clinical practice guideline on cessation states that brief advice by medical providers to quit smoking is effective.

*Alcohol and Other Substance Use and Addiction:* There is a correlation between tobacco use and other chemical substances. Alcohol and tobacco are often cited as powerful bonds for those attempting to quit tobacco.

*Environmental and Occupational Health Hazards:* Environmental (side-stream) tobacco smoke is a workplace hazard, especially for high risk groups such as pregnant women and employees with existing health conditions such as asthma and heart disease.

*Intentional and Unintentional Injuries and Violence:* Tobacco is a leading contributor to house fires, which causes burns and death.

*Overweight, Obesity, and Lack of Physical Activity:* Tobacco companies advertising often leads many young people to believe that by using tobacco products they will become thin and improve their image.

*Social and Economic Factors that Influence Health:* Selected adult populations have higher than average smoking rates. These populations include: persons with lower educational attainment and blue-collar workers.

*Equitable, Adequate, and Stable Financing:* Funding at the local level identified in the Centers for Disease Control *Best Practices for Comprehensive Tobacco Control Programs*, August 1999, will provide for meaningful reductions in tobacco use and health care costs in our state.

### **Significant Linkages to Wisconsin's 12 Essential Public Health Services**

*Monitor health status to identify community health problems:* Tobacco use continues to be a leading cause of premature death in Wisconsin. Monitoring local tobacco use rates provides an indicator of future health problems. Ongoing surveillance will lead to identification of best practice programs within our state.

*Identify, investigate, control, and prevent health problems and environmental health hazards in the community:* Tobacco is the leading cause of premature death in our state. Smoking cessation programs improve the health status of the smoker and others who are exposed to environmental tobacco smoke.

*Educate the public about current and emerging health issues:* Tobacco education is the most cost-effective method in reducing tobacco use. Community support of tobacco control programs is achieved through community education.

*Promote community partnerships to identify and solve health problems:* Local coalitions which include members reflective of the community at-risk, as well as schools, healthcare, voluntary organizations, elected officials, and traditional public health partners will be most successful.

*Enforce laws and regulations that protect health and insure safety:* Smoke free environments provide a positive environment for those adults and young adults going through the quitting process. Enforcement of local and State laws ensure such environments.

### **Connection to the Three Overarching Goals of Healthiest Wisconsin 2010**

*Protect and promote health for all:* By helping smokers quit and supporting comprehensive tobacco control efforts, the immediate and long-term health impacts caused by tobacco. According to 2000 Burden of Tobacco report, Wisconsin loses approximately 7,300 lives per year and spends almost \$1.6

billion in health care costs due to tobacco related death and disease. In addition, 95,000 years of life are lost and there is over \$1.4 billion in lost productivity due to illness and premature death.

*Eliminate health disparities:* The primary disparities are related to socioeconomic status, but specific ethnic communities have higher rates of tobacco use and tobacco-related death and disease. By promoting cessation and tobacco control efforts that focus on disproportionately impacted populations, long-term health improvements will be realized in specific populations.

*Transform Wisconsin's public health system:* We must all share in promoting effective public health systems. By implementing a comprehensive anti-tobacco effort, effective assessment, assurance, and policy development activities will be supported at a state, regional, and local level. The regular review of data allows for ongoing policy and program improvement that will assure public health systems address the burden of tobacco in Wisconsin.

### **Key Interventions and/or Strategies Planned:**

Provide a comprehensive approach to cessation as outlined in CDC Best Practice Guidelines including:

- Promote and support comprehensive tobacco prevention and control efforts on university and college campuses, including counter-marketing, cessation services, social norm campaigns, and smoke-free dorm and facility initiatives.
- Increase availability of population-based counseling and treatment programs. A variety of cessation interventions are effective including: advice to quit by clinicians; individual and group counseling; telephone helplines; and the U.S. Department of Food and Drug Administration's approved nicotine replacement therapy.
- Support the implementation of the clinical practice guidelines for cessation as identified by the Agency for Healthcare Research and Quality, which concluded that the efficacy of intervention increases with intensity.
- Advocate for treatment of tobacco use under both public and private insurance while eliminating barriers to treatment for underserved populations.
- Support increasing excise taxes on tobacco products as doing so reduces tobacco consumption rates. These taxes should support effective community, media, and school programs.

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